

Terrence Holt, Internal Medicine
(NY: Liveright, 2014).

I WAS STILL IN THE PARKING GARAGE WHEN MY pager went off. The callback number was the ER. Naturally I was annoyed. This was week three of my first ICU rotation as a resident, and I was cranky with stress and lack of sleep, but even without that there was reason to be annoyed. The MAO is supposed to stall admissions between six and seven in the morning, out of courtesy to the team coming on call, which is busy getting ready to round. But the problem with critical care medicine is that some things can't wait down in the ER while the rhythms of hospital life play out. So, annoyed but not surprised, I returned the page.

THE MAO, WHO HAD been up all night, was inexcusably cheery. "You're gonna love this one," he said.

"What?" I said flatly.

"Be that way. But you're still gonna thank me."

I grunted, having lost a parking space to an incoming medical student.

"Anyway, what we got here is a sixty-two-year-old lady with a big ICH, she's—"

"Neurosurgery go home already?" I knew the futility of the question, but I had to make the attempt.

"Neurosurgery's seen her and signed off. They said . . ." I heard paper shuffle. "Here: 'prognosis is dismal.' They used the *d*-word. It's a chip shot."

I grunted noncommittally. I didn't want to involve myself in the MAO's creepy good cheer any more than I had to.

"She stable?"

"For now. Ventred, obrunded, holding her pressures."

"Family?"

"Family's all here, I've talked to them, they seem reasonable, but I left the dirty work for you. You do it so well."

I ignored him, grunting one more time as I finally wedged my car into a space vacated by a departing night nurse. "Don't let the family get away."

"Don't worry. From the look of things, they're here for the duration."

IT WAS ALMOST TEN before I made my way toward the ER. In the meantime, in a none-too-surprising violation of custom, the ER had decided to send her up to the ICU before I'd had a chance to see her, so as the elevator opened I found myself facing a gurney bearing a large, unconscious form, a ventilator, a nurse, and a respiratory therapist. My doorway survey told

me this patient wasn't going to be on my service very long. I heard the echo of the MAO's breezy chuckle and suppressed a grimace.

"This lady with the head bleed?"

"You got it," the nurse said, leaning hard to get the gurney into motion. It lurched out of the elevator, dragging the vent and IV pole behind it. I lent a hand, swiveling the assemblage out into the corridor.

"The family coming up?"

"They're probably in your waiting room already."

We got the patient into a room, settled a few questions about the vent, and I spent a minute rummaging through her chart, jotting down a name, age, and record number. There was a brown jacket with a CT from an outside hospital. I held it up to the fluorescents overhead. You didn't need to be a neurologist to call this one: there was an inky cloud larger than a golf ball low down on the right side of her brain. It was blood. It also marked a region of dead and dying brain cells, killed by pressure from the expanding mass. With a bleed like this, there's essentially nothing to be done. There's no avenue of approach for the surgeons that won't destroy more than they could save. If the bleeding doesn't stop, eventually the rising pressure in the skull will extrude the brain through a narrow opening in the membrane that supports the cerebrum within the skull. This process is called herniating: it's inexorably fatal, but not all that common. From the looks of this one, she didn't seem about to herniate. But it didn't look like she was going to survive, either: the hole in her brain was big, and it was low, down where the essential circuitry of life is wired.

I WAS MARSHALING ALL of this largely automatically, as I moved from the smoky shadows of the CT to the patient herself, flashing light in her eyes, tapping on her joints, trying to elicit signs of withdrawal from pain. I wiggled the ventilator tube and she grimaced, slightly: the right side of her mouth curled back in a vague snarl. But the left side was motionless, slack, a slice of eye visible below the lid. With a last glance at the monitor, where a green light kept tracing a steady heartbeat, I made my way out to the waiting room.

AT THAT HOUR OF the day, the waiting room is usually empty; the TV set muttering to itself in a waste of polished blond wood and dusty fabric plants. This morning almost every chair was full. There were children sitting listlessly on the floor. Teenagers slumped in uncomfortable postures, small knots of couples and siblings and cousins and aunts and neighbors and friends and one frail-looking old man wearing a baseball cap with the name of a feed supplier on its stained green front.

"Are you the Wallace family?" I knew the answer, of course, but the sheer size of the crowd had me taken aback. I had a sense of things possibly escaping my control.

From the assembled multitude there came a rumble of assent.

I moved into the room, not sure where to position myself. "I'm one of the doctors taking care of Mrs. Wallace now," I began. I looked at the frail old man. "Are you Mr. . . . ?"

He looked at me with an expression of absolute incomprehension, his head wavering on his skinny neck. "That's him," somebody said. "That's her husband."

I moved closer to him, propping myself on the edge of an end table. "Mr. Wallace?"

He nodded.

I identified myself again, and then paused. I did that partly to give myself a moment to think, partly to let them know that something bad was coming.

"I'm terribly sorry to have to tell you this," I began. A low murmur ran around the room. "I've just come from the intensive care unit, and though I'm just beginning my assessment, I'm afraid that I have to agree with the specialists who saw her in the emergency room."

At some point in my training, I was told that it was useful in situations such as this to say "specialists." It lends authority. It helps people take in the facts they don't want to know.

"From the tests they've done, and my own exam, I'm afraid her outlook at this point is very bad."

I stopped again to let it sink in.

"I can't say at this point if she's going to live."

Another murmur. "That's in God's hands," a voice said, followed by, "That's right. That's right," from all around the room.

"That's right," I agreed. I have little knowledge of God, but in situations like this I've found it's useful to agree. "Her fate is out of our hands."

Another long silence.

"Or I wish it was, anyway." This elicited another murmur,

audibly puzzled. The old man was looking at me as though I were a hallucination.

I sighed, a completely unscripted sigh.

"The problem is," I went on, "we're keeping her alive. We have a machine breathing for her." I looked around the room. There must have been at least thirty of them, all looking at me. "And tubes running in and out of her. She's on life support. She can't speak for herself now. She needs you to speak for her." Another murmur of assent. "And the question she's going to need you to start thinking about—and may need you to answer very soon—is this: Do you think she would have wanted all this?"

A prolonged rumble. The old man in front of me gave no sign he'd heard a word. His eyes—a startling, cloudy blue—weren't tracking on anything. The tremor of his head went on as though hidden devices were gently stirring him. The rumble rose around us to a scattering of broken words, until finally, from close at hand, a stout woman in her forties said, "What'd happen if you turn off the machine?"

"Then it would truly be in God's hands." As soon as the words were out of my mouth, I wanted to call them back. I have no business invoking God.

But my words called forth another murmur of assent. "Turn it off," a voice in the back of the room said. There was another rumble. "She didn't want all this."

This was, of course, what any resident in the ICU would want to hear, and I was relieved to hear it, if a little surprised to hear it so soon. To some extent, this relief is only a humane response to an inhuman situation. In too many cases we keep

bodies alive in a way that is only cruel, cruel in direct proportion not only to its futility, but also to the manifold distresses, large and small, physical and spiritual, inflicted by technologies that only put off the inevitable end. To another extent, always there, undeniable but uncomfortable all the same, this relief is a response to the inhuman load of work and worry that comes with the ICU, caring for too many patients and making too many decisions, and too often failing in our task.

But this was too fast. The atmosphere in the room was a little too much like a revival meeting. The enthusiasm was making me nervous. I stood, and started to back toward the door. "You all need time to discuss this. I'll be here if you have questions. I just want you to remember that the decision has to be yours. We can't decide, and she can't tell us. So you have to speak for her."

I scuttled out of the room as fast as I could.

I DON'T KNOW HOW many times I've given that speech, or some version of it, in one small room or another, in one hospital or another. It's a speech that needs speaking, God knows. No one gets up in the morning expecting to end the day in the ICU, but every day those beds get filled. And very few of the people in them can tell me how they feel about what we're doing to them.

I know how I feel about it. During morning rounds one day late in my intern year, after a night in which all fourteen patients under my care had seemed to be doing their level best to die, I came out of the haze to hear another exhausted intern

make a suggestion regarding a patient whose acute pancreatitis had caused her lungs to fill with fluid. The doctor in charge, to whom the suggestion was addressed, had thought for a moment, then replied judiciously, "We could do that. It *might* kill her." In my delicate state of mind, I missed the irony of that remark. What my overwrought imagination heard instead was a conversation coming from an ICU in some horrible parallel universe, where the goal was not to save the patient, but to kill her, as slowly as possible. Looking around the unit, at the glassed cubicles where bodies hung from a network of tubing and wires strung over the abyss, it occurred to me that, if such had been our aim, the place would not look all that different. It would not look different at all.

But after rotating through the unit several times, I came to understand what my peers were saying when they said they enjoy the ICU, even though I knew I would never share the feeling. There is a simplicity about unit work, a freedom from the messy problems of discharge and placement, even from many of the refinements of therapy. The things we do to people there are for the most part brutal, simple, and effective. We sustain breath with an adjustable air pump. We support blood pressure with any combination of four different drugs. We fight off infection by the simple means of hosing down the patient with the three or four antibiotics necessary to cover the entire spectrum of known pathogens. The patient doesn't talk back. The patient doesn't move. The nurses are generally brilliant. As medicine, it's relatively simple. And there is a pure and uncomplicated pleasure in taking a patient who is minutes away from death and dragging him out of darkness into light.

The problem, of course, is that sometimes you fall short of that goal. Too often, we're able to rescue somebody from death, but can't quite bring him back to life. People get stuck in that horrible twilight in between. And while they may not be able to tell you, it's difficult to escape the impression that, even if they could, they wouldn't want to thank you. This is something that can be difficult for people to understand, especially when the patient is someone who just that morning, or the week before, had been a fully living, fully functional, and deeply loved human being.

We practice a scrupulous ethics in my hospital. Patients decide the limits of their care. If they can't talk, the family tells us what to do. And no matter what I think of their decision, I am bound to respect their wishes, up to the point where my efforts are clearly futile, and then the question is moot: at that point, usually, the patient speaks in the only way left to him, by dying despite everything I can do. Whenever the decision is taken out of my hands, I feel relieved. Who would want the power to decide?

AROUND THE MIDDLE OF the afternoon, I was down in the ED working up a new admission (eighty-three-years-old, living alone, found unconscious on the floor with a core temperature of 107 degrees, and now barely holding her pressures on ten micrograms of dopamine) when I was paged to the ICU. The Wallace family wanted to speak to me. In the interim, Muriel Wallace's condition hadn't changed in any significant way. There was no sign her stroke had progressed. Her blood

pressure was stable, her heartbeat solid as a rock; as I prepared to meet the family, this, and the way she was breathing over the vent, made me slightly uneasy—the way one always is in the hospital when things don't progress according to plan.

"Breathing over the vent," means the patient is taking breaths without the aid of the ventilator. Ventilator management can be complicated; in patients whose lungs are severely damaged, the subtleties of their settings become a matter of art as much as science. But for most patients, as for Mrs. Wallace, the machine was there simply because she was intubated, and it's hard to breathe through a narrow tube without mechanical aid. The tube itself was there only because she was unconscious: she was intubated for airway protection, and the vent was on minimal support only, supplying breaths twelve times a minute, and giving a helpful push on any breath the patient started drawing on her own. Even on her own breaths, she was drawing in more than the vent supplied. Odds were good that if I were to extubate her, she would go on breathing.

This made me uneasy, I say, as I found the family and ushered them into the conference room across the hall—dozens of them squeezing in until the room was walled with standing, silent figures. Around the table by some tacit agreement most of the elders had arranged themselves in some order of precedence. Mr. Wallace sat at the far end, wobbling, unseeing, fragile. I didn't have the time to figure out for myself just where this plot seemed to be headed. With her massive bleed yoked to her unimpaired respiratory drive, Muriel Wallace was entering a gray area.

But I was running on autopilot, feeling pressure to move

on to some next step in the process. My pager had buzzed twice while the family was filing in. One of the new admissions was crashing. I had a sense of events piling up just outside the room.

A large, stout woman to Mr. Wallace's right—unmistakably Muriel's daughter—spoke.

"We've been discussing," she began. "Like you said."

I nodded encouragingly. She went on. "We'd like to begin by saying how much we appreciate . . ." She paused here, and the silence filled itself with muttered assents. "Appreciate," she said again, "all the care you've shown our mother."

"And aunt."

"And sister."

"Amen."

"We truly do," the woman went on. I could hear a "but" looming, and settled myself, trying to remember that I wasn't here to argue. I wasn't pushing an agenda. I was here to help. My pager was going off again.

"But." And her gaze swept around the room. No one stirred. "We have some questions."

I murmured some polite invitation.

"What," the woman began, "are our options here?"

I thought for a minute. "I suppose there are three." But that wasn't right. I was skipping something. "But before we discuss them, I thought you'd want to know how she's doing."

Yes, they sighed.

"She's unchanged."

The sigh flowed out of the room.

"She's not better and she's not worse." This seemed to me

to sum up the salient features of the case. I plowed on with details.

"She's still unconscious. I have no idea when or if she'll wake up." I paused, letting the room absorb the sound of my voice. "Meanwhile, she's still on the breathing machine." I stopped, wondering where to go next. "But she's not using it." This elicited some stirring, eyebrows rising, nods exchanging, heads shaking. "She's breathing in and out without any help from the machine."

"What does that mean?"

It was messy was what it meant. But I wasn't sure how to say that. "It means, basically, that her stroke hasn't gotten any worse. The reflexes in the base of her brain, the parts that control breathing, they haven't been hit. We could take her off the machine right now and she'd probably do fine." No, that wasn't right. "Fine" wasn't right at all. But the words were out.

"Then let's do it," a voice said. The daughter stabbed him with a look, and turned to me.

"Is that one of our options?"

"Yes. It is. But there's a problem. With what's happened to her, it's very likely that she can't control the muscles in her throat anymore. All the reflexes that we use to keep from choking, to keep things from going down the wrong way—those don't work anymore. We'll need to do some more tests, but it's very likely that if we take the tube out, eventually she'll choke, inhale something she shouldn't, and get pneumonia."

More solemn nods from around the table; glances shifting side to side. I went on. "If that's the case, then our options would be: to keep her the way she is now, to pull the tube out,

and" — for a moment I considered referring to God again, but thought better of it—"let nature take its course. Or, if tests show us she needs it, we could have the surgeons put a permanent breathing tube in here." I gestured to my own throat just above the sternal notch. "It's called a tracheostomy, and it would allow her to breathe on her own. It would also offer some protection against choking."

I stopped, not so much letting things sink in as wondering myself where we were going. I was thinking of how long it would take all this to unfold: days and days. And to what end?

"This breathing tube," the daughter asked, "is that a big operation? Will she stand up to it?"

"She shouldn't have any trouble."

Another woman, another daughter from the looks of her, chipped in from down the table. "And can she go home after that?"

That was another question. I paused a minute, this time judging the effect—going for an effect, I realized. What was I trying to do here? "I don't know," I said. "There's no way of knowing for sure. But I doubt it. From what we've seen so far, the damage is so severe, it's unlikely she'll ever rise from that bed again. Usually, with this kind of injury, you're looking at a life in a nursing home—"

Mutterings of protest. Under the glare of the daughter, they died away.

"A nursing home would really be the only place that could care for her. Dealing with somebody so severely paralyzed is hard work. There's constant care involved."

"We can do that," somebody said.

Don't argue, I told myself. "It's very hard," was all I said. "But that's not the issue we need to resolve. Not right now. The question you all need to decide is, would she want that? If all we can buy her is a little time—with frequent infections, bed sores, being unable to do anything for herself—do you think that's what she would want?"

As I said this, I could feel myself becoming increasingly uncomfortable. Not with the question itself: it's a common enough question, and one that needs to be asked—sometimes. As I listened to the sound of my voice dying away in the room, even the echoes struck me as wrong. Wrong and wrong and wrong: mistakes seemed to be showering out of me like sparks from a Catherine wheel. Listen to me, I thought: It sounds like I'm pleading with them to let her die. Like I *want* this woman to die.

Well, of course, on some level I wanted something close. There was nothing complicated or remarkable about that. Any resident who is remotely honest will tell you we become, if not comfortable, at least familiar with the sensation of wanting patients to die. We feel that way because they're going to die anyway, usually, and we know that, out of the available options, dying quickly is the best that could happen to them. But it's also better for us. There's the rub. It saves them agony, but it seems to save us something as well: the exhaustion of watching, of causing nothing but pain as we struggle to forestall the inevitable.

Of course, it doesn't really save us even that. Whatever hospitals once were, they are now largely places where people come to die. If they're not at death's door we rush them back home;

only the dying linger, but in this parallel universe every dying patient is quickly replaced by another. The house staff come to see the ICU as the place where we manage that exchange, again and again and again. The feeling is understandable. It's also, thank God, temporary, fading like bad dreams with the light of day as we get more sleep, more time with our patients, as we move up the hierarchy so that we're not the ones actively, physically, holding off death just a few seconds more.

So there I was, using all the rhetorical tricks I had at my command, I feared, to seem to push this family into pulling the plug on my patient. Was I really doing that? It would be better for the patient, after all.

And it was my job, I told myself, to help them face up to a reality most of us would rather deny. Too few of us arrive at the hospital with a duly signed and witnessed DNR order in our hands. Too few of us have the conversation with our families. And nobody out there seems to understand that the survival we have to offer is sometimes worse than—I had been going to say "death," but I don't know enough about death to use it in a comparison. Worse than what? Worse than I want to give? Perhaps it's that. I would save everyone if I could, but it's a sorry gift I have to offer, sometimes. Life in a puddle of urine, bones laid bare as the immobile flesh turns black and rots away, long hours passing while a call for something simple—a drink of water, a runny nose wiped clean—goes unanswered. I didn't want that life for Muriel Wallace, for any of my patients, for anybody.

But with every unassisted breath Muriel Wallace took, I was beginning to understand that what I wanted did not

matter. My rhetoric did not matter, except insofar as it might impose my half-baked wishes on events. Muriel Wallace's life was following its own plot. It had always been that way, I knew, but just then the reality of it left me feeling bleak, uncertain of where to go next. And the entire family was still looking at me.

There were more questions, which I did my best to answer, talking on autopilot about infections, fiber endoscopies, and skilled nursing. While the family threshed through the matter, discussing things I had no business hearing, I excused myself. They would let me know. I went across the hall and back into the Unit, moving through the noise of the nursing station to the dark and relatively quiet room where Muriel Wallace lay. She was still: a big, still woman with white plastic tubes taped to her face. Gently, I jostled the end of the endotracheal tube. No response. Out of habit more than any actual curiosity, I put my stethoscope to her chest: air moving in and out, backed by the rhythmic thud of the living. Her left arm was limp, utterly flaccid, falling when I let it go in a straight drop to the bed. A big, still woman lying motionless in bed.

ANY PATIENT IN A HOSPITAL, when we take their clothes away and lay them in a bed, starts to lose identity; after a few days, they all start to merge into a single passive body, distinguishable (if even then) only by the illnesses that brought them there. In the ICU, with consciousness gone as well, there is rarely a trace of personality left behind. Spirit itself

comes from a machine. The body remains behind, but all too often it's a husk, doing the work of living for nobody's benefit. It's impossible to know what's going on in there. It's impossible to read how the body came to be there, what life it left behind. Just the rise and fall of the chest, the slow accumulation of data as labs and vital signs and consults and imaging fill up the chart, telling nothing about the person they surround.

But the question of Muriel Wallace and her care had become a question not of medicine but of an unknowable will. What would Muriel want? It was clear enough that she had had a stroke that should have killed her, and was certainly, I thought, going to leave her hemiplegic forever. She had to look forward to a future of infections of the lung, of the bladder, and then the slow ripening of sores. There was no easy solution for the problem of being Muriel. None that I could give.

And none that she could give, either. We go along in our lives, making plans, expecting things will continue the way they have, confident that we know what we want, what we might and might not have. But lives don't go like that: no matter what we will for ourselves or others, time hides abrupt and wrenching dislocations, moments that change everything. Muriel had been through one of those moments. And after that, what anybody knew, what anybody wanted, was irrelevant. More and more the facts seemed to tell us that she was going to live. She was going to have to live with what happened to her. I picked her limp arm back up, folded it across her, covered it with the thin hospital sheet. She gave no sign. The ventilator heaved a sigh as I left the room.

I WISH I COULD provide something neater to end this piece. It didn't end neatly—hasn't, for all I know, ended at all. Muriel survived our care. She did develop pneumonia, but anyone will in her situation: we were waiting for it, and she responded within a day or two to antibiotics. Later, she woke up, just as her family had hoped. She even greeted me one morning with a half-wide half grimace, a strong grip with her good right hand. She nodded vigorously to almost any suggestion, nodded and squeezed about getting the trach and the G-tube, and as soon as her fever was down, on two successive days she got them both installed, and we were able to wean her off the vent without a problem, and the nurses started to teach her family how to pour into her G-tube the cans of gray-green liquid that from now on would be her food. Then, her need for intensive monitoring past, we transferred her to one of the general medicine services, who would manage her care until she had a bed somewhere beyond our walls.

AS LUCK WOULD HAVE IT, I followed her a day or so later, rotating off the ICU to general medicine. My first day on the service, the family greeted me like lost kin. They were no longer a collective tableau of grief, resolving instead into individuals, who spoke, gestured, laughed. That day they were laughing—gently, happily—at me. Pulling me into the room during rounds, they interrupted the intern's presenta-

tion with a delighted—and slightly ironic—demonstration of Muriel's ability to move the toes of her left foot, the ghost of a grip she had developed in her left hand. Muriel beamed at me as she showed us what she could do. The intern beamed and completed her presentation. The plan for Muriel, for the remainder of her stay, was physical therapy, speech therapy, occupational therapy, and social work consultation for placement. The family had agreed to place her in a nursing home for rehab, confident that it would be a short sojourn before returning to the life she had known. I beamed back at them, nodding blindly, not looking at the figure still splayed so limply on the bed.

ON THE DAY OF her transfer to the nursing facility, Muriel was found unresponsive, and hypotensive to the eighties over forties. It seemed for a moment that her story had taken another turn, or turned back, anyway, into the usual course of things in the hospital. She spent that night in the ICU again, getting a liter of fluid. That fluid may or may not have been responsible for the recovery of her pressures. At any rate, something turned this climax into peripeteia: the story continued, again taking its own path to its own end. For now, at least, she rebounded. What set her back in the first place? Nobody knew. Things like this were to be expected. By the next day she was back on the general medicine service, and the day after that, her family took her away. I didn't see her go.

In the years since then, I've thought about her often, wondering how she's getting along. It would be easy enough to find out how her story finally ended, but I've resisted. I'd like to leave her the way she is, lying in that bed with her family so pleased, beaming at me because I was wrong.



HEART FAILURE



*Let the lamp affix
its beam*